DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445242	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE HEALTH CARE CENTER	181 DUNLAP ROAD BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to maintain doors protecting corridor openings. The findings include: Observation and testing with the maintenance director, on 7/25/16 at 12:13 PM revealed the 1st floor unit coordinator office and 2nd floor clean linen require 2 releasing motions. (NFPA 101, 19.2.2.2.4, 19.2.2.2.5, 19.3.6.3.2) These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 7/25/16.	K 018	*"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."* K 018 1. The main striker or the 1st floor unit coordinator office and 2nd floor clean linen has been blocked with a metal plate to render it inoperable, leaving only 1 releasing motion required. 2. All doors in the facility were audited by 8/18/16 to insure none required 2 releasing motions. No other doors were found to be deficient. 3. Doors will be audited twice a month for 3 months. The preventive maintenance log will have an annual review of all doors for compliance. 4. Results will be presented to the QAPI committee for further action.	9/9/2016 09/11/2016
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall	K 052		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/19/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445242	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE HEALTH CARE CENTER	181 DUNLAP ROAD BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 1 be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the fire alarm system in accordance with NFPA 72. The finding includes: Observation and interview with the maintenance director, on 7/25/16 between 11:50 AM and 2:55 PM revealed a missing visual/audible alarm in the compartment of the 2nd floor nurses station and no fire alarm pull stations within 5 feet at the main front exit and the main dining room exit. (NFPA 72, 4-4.4.2.1, 4-4-4.2.2, 2-8.2.2) These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 7/25/16.	K 052	*"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."* K052 1. A Visual/audible alarm will be placed at the 2nd and 3rd floor nurses station. A fire alarm pull station will be placed at the main front exit and at the main dining room exit. 2. 1st floor nurses station has a visual/audible alarm already in place. Upon an audit of the facility, no other pull stations were out of compliance. 3. Any facility modifications will include approval of the state Fire Marshall. 4. The QAPI committee will review completion of all tasks and future submissions of facility modifications.	9/9/2016 ~~09/11/2016~~
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system. The findings include:	K 062	K062 1. 11 new quick recover sprinkler heads will be replaced so that there will be no mixed sprinkler heads in the following areas: 1. 1st floor nurses station and scale storage. 2. 2nd floor dining room and scale storage 3. 3rd floor scale storage	9/9/2016 ~~09/11/2016~~

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445242	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE HEALTH CARE CENTER	181 DUNLAP ROAD BLOUNTVILLE, TN 37617

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 2 Observation and interview with the maintenance director, on 7/25/16 between 12:26 and 1:30 revealed mixed sprinkler heads in the following areas; 1. 1st floor nurses station and scale storage. 2. 2nd floor dining room and scale storage. 3. 3rd floor scale storage. (NFPA 13, 5-3.1.5.2) These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 7/25/16.	K 062	*"Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."* 2. The facility was audited and no other mixed sprinkler heads were found. 3. Any facility modifications will include approval of the state Fire Marshall. 4. The QAPI committee will review completion of all tasks and future submissions of facility modifications.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain generators in accordance with NFPA 110. The findings include: Observation and interview with the maintenance director, on 7/25/16 at 11:17 AM revealed the generator transfer switch rooms for rehab and the main building were not provided with emergency lighting with battery backup. (NFPA 110, 5-3.1) These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 7/25/16.	K 144	K144 1. The generator transfer switch rooms for rehab and the main building were equipped with emergency lighting and battery back up by 8/26/2016. 2. These are the only rooms requiring emergency lighting with battery back up that are not appropriately equipped. 3. Rooms requiring emergency lighting with battery back up will be checked monthly and placed on the preventive maintenance checklists. 4. Results will be presented to the QAPI committee for further action.	9/9/2016 ~~09/11/2016~~